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VAGINAL DISCHARGES

By ALAN BREWS

DISCUSSION

A SMALL series of pathological specimens from the Gynæcological section of the London Hospital Medical College Museum was shown by Mr. Brews. They had been chosen to illustrate some of the gynæcological causes of vaginal discharge of common interest to the venerealogist and the gynæcologist. Included in this series were :—

(1) The wall of a chronic Bartholin's cyst dissected out of the labium majus. It was stressed that when a thick fibrotic lined by granulation tissue had developed it was unlikely that any form of drainage or medical treatment would result in a satisfactory permanent cure.

(2) A uterus that showed bilateral hydrosalpinges, a pool of Lipiodol being present in each dilated Fallopian tube. X-ray pictures illustrated how the Lipiodol had been injected through the uterus into the tubes in the course of an investigation for sterility. If Lipiodol could pass easily upwards it was obvious that the fluid contents of the tubes could pass downwards, and that such a specimen illustrated a clinical condition of intermittent hydrosalpinges, and was a possible cause of a periodic profuse vaginal discharge. Lipiodol uterograms should have a place in the investigation of certain chronic venereal infections which failed to respond satisfactorily to the usual methods of therapy.

(3) Multiple warts excised from the vulva. The patient had a positive Wassermann, but the warts failed to improve clinically with anti-syphilitic treatment. No bacteriological evidence of a gonococcal infection was obtained on repeated investigation. Such cases were usually regarded clinically as venereal in origin, but at present it was difficult to prove this assumption satisfactorily by bacteriological means.

(4) Diffuse adenomatosis of the vagina. The patient had a persistent, copious discharge for 7 years, which resisted many forms of local treatment. A complete

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uterovaginctomy was ultimately carried out with complete cure of the patient's symptom. Such cases are of interest in that they are not infrequently associated with glandular carcinoma of the cervix.

(5) An early carcinoma of the upper part of the cervical canal. The presenting symptom was a yellow vaginal discharge without any abnormal hæmorrhage from the genital tract. The only physical sign on clinical examination in the lithotomy position was the escape of a small amount of pus from the external os. It was the curette, after a preliminary dilatation of the cervix which resulted in the diagnosis being made.

THE PRESIDENT said he was sure he was expressing the feelings of all present when he cordially thanked Dr. Brews for his paper; he had himself followed it with great interest and pleasure. Its effect upon him had been to reduce some confusion of ideas on the subject to some degree of clarity.

DR. LYNETTE HEMMANT said she was very interested in Dr. Brews' paper, from which she had learned a great deal. She particularly noted the remarks concerning the physiological character of the leucorrhœa after menstruation; many women complained of having a little discharge towards the end of that monthly function, and she usually told them it was a normal happening, and there was no need for them to fuss about it. A similar remark could be made about individual excess of leucorrhœa. Many women sweated more than the average in the axillæ, and they probably also sweated from the vagina, and no treatment seemed to reduce its amount.

As to the attitude of the venereal worker towards laboratory reports on specimens, the speaker apparently thought these reports were accepted too readily. The truth was the venerealologist was very sceptical about them. One positive report did not make a disease, any more than one swallow made a summer. Tests were repeated, especially when the report seemed to contradict the clinical findings.

She asked whether Dr. Brews had had experience of leucorrhœa having followed the use of vaginal contraceptives, such as the Dutch cap pessary.

COLONEL HARRISON repeated, on his own behalf, the complimentary remarks which had been made concerning

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Dr. Brews' paper. He thought that gentleman was too modest. It was fascinating to note the way in which he got down to first principles, which so many speakers seemed to forget.

All he had to say, in detail, was concerning the bacteriological diagnosis, and the difficulties in that regard in places where no laboratory was accessible. He had one suggestion to make. It was that the specimen of secretion would travel well to the laboratory for cultural investigation in a capillary tube. In some pre-war experiments which he made he found that the gonococcus would live in its native medium in an ice-chest for several hours so that it could be cultivated next day. Later Dr. Osmond had found it could be cultivated from gonorrhœal discharge that had been kept in a capillary tube at room temperature for some days.

The next question which arose was as to how to get secretion from the cervical canal into a capillary tube. He had had an opportunity of putting this idea into practice a few months ago when examining a number of women to discover the source of a case of gonococcal ophthalmia in a little hospital not fitted with a laboratory. He found it difficult to fill the tube directly from the vaginas, but this difficulty was overcome by transferring the secretion in droplets to sterile test-tubes. Then having gathered a reasonable quantity in that way, he was able, from the sterile tube, to fill the capillary tube in which the discharge was despatched to the laboratory. He thought that if this method were practised, greater use could be made of the cultural test.

MR. AMBROSE KING added his own congratulations to those expressed by others concerning the excellence of this paper. He had listened intently to the remarks about the slavish worship of the positive test and the ignoring of the negative. He agreed there was a good deal in that criticism. Still, the reader was scarcely in a position to realise the difficulties and the uncertainties with which the venereologist was faced. One frequently saw women patients who had infected their consorts and themselves had signs of chronic infection, yet, in the room, one could not isolate the gonococcus by frequent and careful tests. And as such cases were seen quite frequently, one was filled with the idea that the pathological tests had not yet reached that pitch at which they

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could be trusted absolutely. And, however careful one might be, and with whatever expertness the tests might be done, there seemed to be times when the medium was not as good as at other times. That was something which pathologists had not yet mastered.

Mr. Brews' suggestion that the Gynæcological and the V.D. departments at a hospital should be in close association was a magnificent one, and at Whitechapel he would like that more, perhaps, than anything else.

Naturally, Mr. Brews could not cover the whole of this big subject in the time, but he made no reference to fungus infections of the vagina, such as "vaginal thrush," which was due to the monilla. He asked whether that condition occurred in gynæcological clinics.

There was also the question of senile vaginitis. In certain quarters there was an impression that the gonococcus did not persist in the female after the menopause, but V.D. workers did not believe that. But he was not saying that senile vaginitis was always due to the presence of the gonococcus. He asked as to the relative frequency of the gonococcus in these cases as a causative factor.

Another point on which he would like to hear the opener's views was the vexed question of the expediency of hysterectomy and removal of tubes in the chronic or subsiding stage of salpyngitis. He asked whether Mr. Brews regarded that as a desirable procedure only in the presence of severe symptoms, which were not relieved by ordinary expectant methods of treatment, or whether he regarded it as good treatment to extirpate the urethra if the case was dealt with adequately by the usual means.

DR. G. L. M. McELLIGOTT also added his word of praise of Mr. Brews' paper. He especially thanked that gentleman for what he had said concerning the physiological post menstrual discharge which was microscopically indistinguishable from that of a purulent infective condition. There was a tendency in the clinics, in the case of women who had been attending free from gonococci for months or perhaps years, to hesitate to discharge them on account of the presence of pus cells in the post-menstrual cervical mucus. In the light of what Mr. Brews had said, it seemed to be a duty in these cases to examine the smears and cultures during the intermenstrual as well as the post-menstrual periods.

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MR. BREWS in reply, thanked the Society for their reception of his paper. The gynæcologist and the venerealogist naturally approached the subject of vaginal discharge from a rather different point of view. The difficult problem was that of chronic purulent infection of the genital tract. As a teacher he found it difficult at present to give students a clear conception of the relative incidence of venereal and non-venereal infections in say, 100 women with chronic cervical erosions or chronic vaginitis.

In reply to Dr. Hemmant, he stressed the fact that the vagina after panhysterectomy was not infrequently the site of a simple leucorrhœa. There was no question that normally a transudate from the vaginal squamous epithelium occurred and was liable in some individuals to be excessive in amount.

There is no doubt that in many gynæcological clinics at the present time the methods of diagnosis of venereal infections, especially chronic ones, were very defective. It was in the case where the diagnosis depended solely upon some such finding as a \pm gonococcal fixation test or on a few suspicious diplococci that he felt a consultation with a whole-time venerealogist working in an adjacent clinic would be very desirable, before definitely labelling the case as venereal and setting into motion the machinery that might do the patient much social damage while achieving very little medical improvement by treatment. Both doctors and patients should be taught to distinguish between the methods of treatment which were purely hygienic, such as many forms of vaginal douching, and forms of treatment which were definitely scientific and had a rational scientific basis.

Colonel Harrison's capillary tube method of collecting secretion from the cervix and urethra for culturing should definitely prove valuable in many gynæcological clinics, and he had not realised that in such a tube a gonococcus can be kept alive for some time even in an ice chest.

With regard to post-menopausal, senile vaginitis he had always regarded it as a pyogenic infection grafted on to an atrophic, devitalised mucous membrane. There was no question that Oestrin injections temporarily improve the vitality and resistance of this cervix, and therefore are of great therapeutic assistance. He had not previously realised that the venerealogist not in-

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frequently can culture the gonococcus in such cases, and would certainly bear this in mind in the future investigation of these cases.

Discussing the position of surgery in the treatment of chronic infections of the female genital tract, he felt the position should be discussed in each case with the patient concerned. Generally speaking, the physician can rarely cure a real chronic infection in any part of the body. A course of treatment would diminish or temporarily cure symptoms, but relapses were almost inevitable. In certain situations, such as the teeth and the tonsil, surgical treatment was usually regarded as more satisfactory than years of intermittent medical treatment with relapses. Certain parts of the genital tract can be treated surgically with no interference with its physiological function. In other cases the physiological function has previously been destroyed by the chronic infection, and was therefore not altered by surgical treatment. In those cases where a radical removal of some part of the genital tract would result in cessation of menstruation, sterility, or interference with sexual relationships, then the disability that would be caused must be carefully weighed against the disability that would remain for prolonged medical therapy.

Intra-uterine contraceptive appliances were definitely the cause of vaginal discharge, and were a possible cause of sterility. If ever advised at all it should only be in women with family who definitely did not want further children, and who had clearly understood the dangers of this method. He had no clinical evidence of vaginal discharge resulting from the intermittent use of the cervical cap or vaginal occlusive pessary, but he had seen cases of cervicitis and vaginitis that appeared to be due to the use of chemicals as contraceptive agents.